
Success factors to decrease foreign transplants in Colombia, South America

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Abstract

In 2005, Colombia performed 16.5% of its organ transplants in foreign patients. The total of organs transplanted was 756, out of them, 124 in foreigners. The numbers by organ were: Kidney (598 citizens/95 foreign), Liver (115/22), Heart (37/3) and Lung (6/4). Colombia changed its policy, and created the Transplant Network Organization a subdivision of the National Health Institute (INS). According to the new legal framework, each program must ask to the INS for a written permission to transplant a foreign patient, and the INS should demonstrate that there is not a suitable Colombian receptor for that specific organ.

Otherwise the health system increases the waiting list for each organ and set the network to share organs for one region to another. Several laws, executive orders and a declaration of the Council of State were made in these years to apply the law to the clinical practice.

Over the last years the number of foreign patients transplanted in Colombia decreased and by 2012 it represents less than 0.27% out of the total of organs transplanted. This number is favorable compared with same percentages for other countries.

Key words: Organ trafficking, transplant tourism, transplants in foreigners, transplants in South America, transplants in Colombia

Introduction

In the year 2011 about 112,600 transplants were performed worldwide; the main organ transplanted was kidney with 76,118 cases, followed by the liver with 23,721 cases. Among these were countries such as USA with transplant rates larger than 75pmp, and Colombia which for 2012 has a rate of about 23 transplants pmp, ranking itself in position 44, within the 50 principal countries with transplant activity [1, 2].

In our country, in contrast to others in the region, we have a transplant rate of 23.4 pmp, which mainly corresponds to cadaveric donor transplants and only 11% are from living donors for kidney and 2% for liver transplants. Nevertheless, the overall rate is similar to countries like Brazil, Argentina and Puerto Rico, and well above countries like Ecuador, Peru and Bolivia. Regarding the donation rates for deceased patients, Colombia has a rate of 12.5 donors pmp, with 14,787 total transplants from 1996 to 2012 [2, 3].

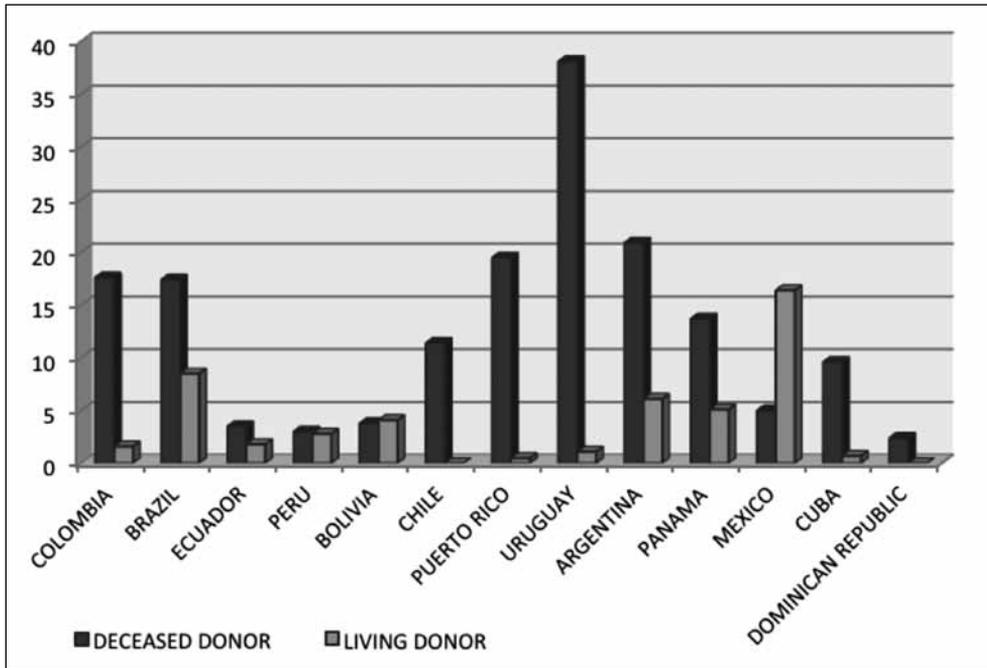


Figure 1: Latin American kidney transplantation 2011 pmp. IRODat: International Registry Of Organ Donation and Transplantation

In Colombia prior to 2004, the transplant rate was around 11 transplants pmp, later it increased and stabilized at around 26 transplants pmp. This was the result of the effective donation and transplant policies introduced, and the creation of the National Transplant Network, which depends on the National Health Institute [2].

Below some definitions given by the declaration of Istanbul on organ trafficking which allow us to understand the problem that arose in Colombia with transplant tourism:

Table 1: Total transplants of solid organs in Colombia 1966-2012. From ACTO

Organ	1966-2008	2009	2010	2011	2012	Total
Kidney	8,321	843	867	798	767	11,596
Liver	1,224	231	211	185	207	2,058
Heart	532	59	60	82	99	832
Kidney-Pancreas	38	10	12	3	5	68
Lung	51	5	6	4	13	79
Combined	47	15	8	6	10	86
Small bowel	2	0	4	2	3	11
Others	44	0	1	3	2	50
Multivisceral	1	-	2	2	2	7

Organ trafficking: The recruitment, transport, transfer, harvesting or receipt of living or deceased persons or their organs, by means of the threat or use of force, or other forms of coercion, abduction, fraud, deception, abuse of power by a position of vulnerability, or receiving payments or benefits [4].

Transplant commercialism: Policy or practice in which an organ is treated as a commodity, including being bought, sold or used for material gain [4].

Transplant tourism: Is the movement of organs, donors, recipients, or transplants professionals, across jurisdictional borders for transplantation purposes [4].

In the article *Transplant Commercialism by Epstein* it said that 5-10% of the total renal transplants worldwide is related to transplant tourism [5].

With transplant tourism, different problems which are well known arise, such as the negative effect it has on local donation and patients being exposed to sub-optimal treatments which results in increased morbidity; infection transmission, many of which may be exclusive or endemic of the country where the transplant is performed; exposure to multiresistant microorganisms and, patients are prone to an improper education both previously and post-transplantation due to the language barriers between the medical group and the patient, which leads to the very poor postoperative follow-up, especially when the patient returns to his country of origin [5-7].

There exist different models of trafficking and commercialization of organs, as presented by Hasan, Khamash and Gaston, in which both the recipient and the donor are moved either individually or jointly to a different country where the procedure is performed. This clearly shows that organ trafficking and commercialization is a global problem with countries like Israel, Saudi Arabia, Oman, Japan, Malaysia, United Kingdom, Republic of Korea, Canada and USA where the donation rate is low or transplant waiting time so long that patients seek surgical opportunities in other places where the law is weak and there are high poverty rates. These are countries such as Irak, Moldova, Pakistan, India, China, Philippines, Peru, Bolivia, and Brazil [8].

In the publication by Delmonico the problems of different countries are explored. For example in China in 2006, over 4000 prisoners were executed for the purpose of obtaining their organs for transplants; transplants which were performed majorly in foreigners. In India the altruistic non-related donors represented the biggest problem until 2008, the year in which payment for expenses of donors in Israel was prohibited. In that same year the entry of foreigners seeking a transplant was banned in Pakistan. Delmonico remarked that in Colombia there was no transparency concerning the number of foreigners' transplants, mainly liver transplants [9].

Colombian problem of tourism and the solution

In Colombia since 2004 different policies have been implemented to clarify and define the guidelines for both donation and transplantation. Additionally this country has signed various international documents and communications like resolution WHA57 [8]. World Health Assembly 2004, the Declaration of Mar del Plata in 2005, the Declaration of Istanbul in 2008, this regarding organ trafficking and transplant tourism in the context of the Latin American Network/Council of Donation and Transplantation. The country also subscribed to the Declaration of Bogota in 2009; in 2010 it adheres to the Madrid Declaration and finally subscribed in Dominican Republic to the Document of Aguascalientes [10, 11].

Concerning Colombian legislation, the Constitution of 1991 makes reference to foreigners being able to enjoy all of the assurances given to citizens of the country when they are in national territory, within the limits of the constitution and law. The previous article was what foreigners used to apply for a transplant prior to the implementation of laws in 2004 [12].

Law 919 of 2004 establishes the penalization of trafficking and commercialization of organs in Colombia, as well as that the donation should be done without any kind of compensation. It also penalizes people who traffic, purchase and/or negotiate any human body parts with a sentence between three to six years of prison [13].

In this same year by Decree 2493 the National Transplant and Donor Network is created by the National Health Institute which conducted the guidelines of donation and transplantation, including living and cadaveric donors, as well as the guidelines for allocation of organs [14].

The same decree specifies that foreign transplants may be performed, provided the waiting list has no Colombian citizens or resident foreigners, both regionally and nationally. It also states that the institution to make this transplant must obtain a certification of regional coordination to ensure the absence of a national recipient on the waiting list [14].

Finally, in 2011 a case law of the State Council made clear the status of non-resident foreigners in Colombia and emphasizes that the waiting list mechanism is not discriminatory and that instead priority that negatively affects national or foreign residents should not be given to non-resident foreigners. It clarifies that the waiting list mechanism is to rationalize the use of transplants. It also establishes that only in the case of extreme urgency or that the patient life is in danger, the priority on the waiting list may be modified [15].

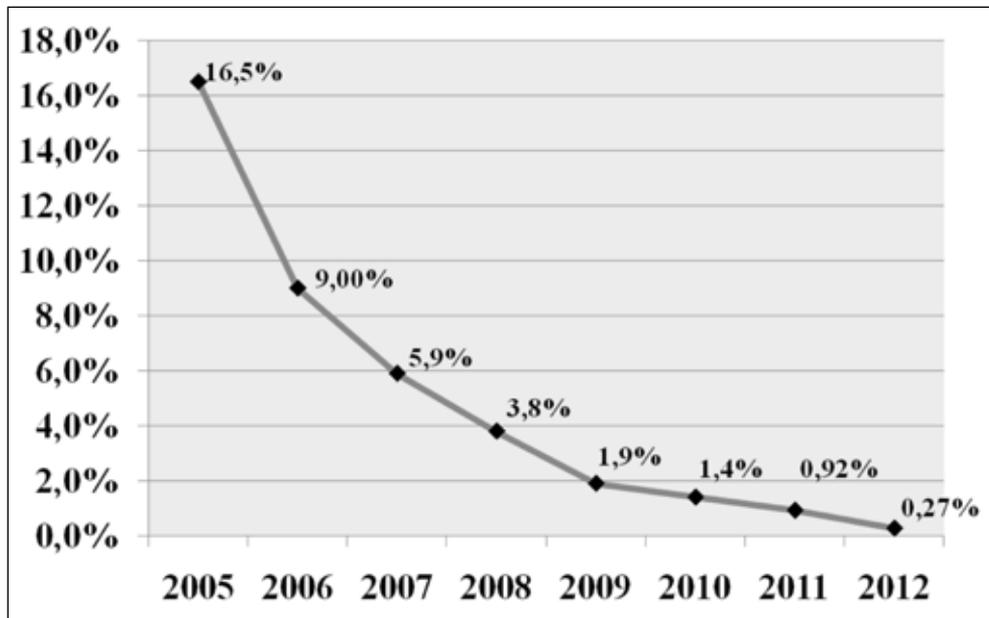


Figure 2: Decrease of the total of foreign transplantations in Colombia 2005-2012

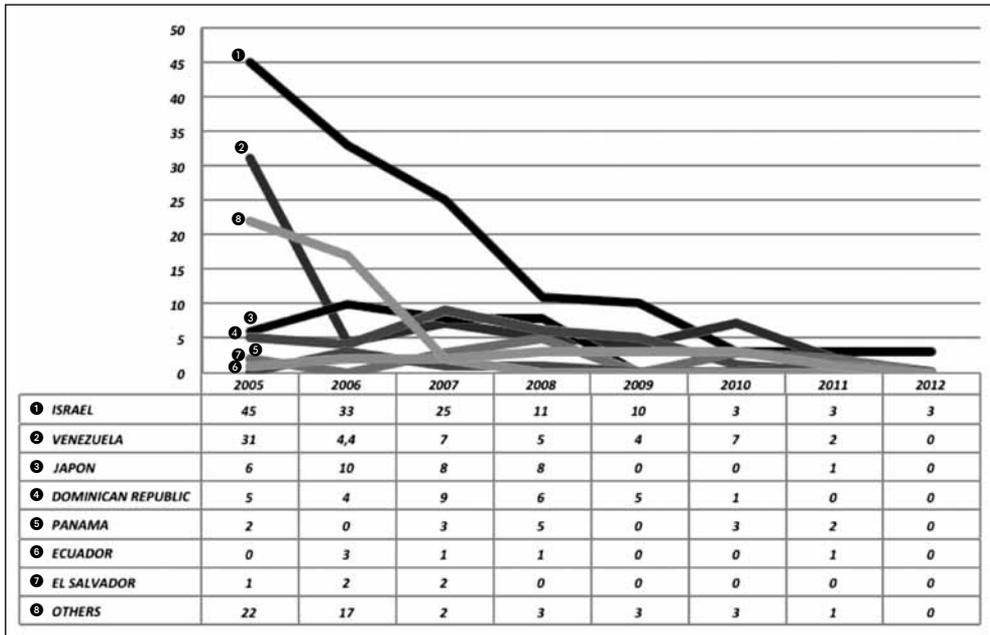


Figure 3: Foreign transplant recipients by nationality in Colombia 2005-2012

The results of the application of these laws are reflected in the steady decline in the number of foreign patients transplanted, from 16.5% in 2005 to 0.27% in 2012. It is noteworthy that by the year 2005 the main nationality of foreign patients transplanted was from Israel with 45 patients, followed by Venezuela with 31 and with a smaller number Japan, Dominican Republic, Panama, Ecuador, among others. In 2012, 3 foreign patients were transplanted, two of which were operated because of a life-threatening emergency [2].

In conclusion, we can say that Colombia is meeting the international recommendations, and that the government and the Colombian health system demonstrate that they are against organ tourism and organ trafficking.

The allocation of organs is carried out in compliance with the law, the principles of universality, equity, equality and justice; every transplant center in the country is following the policies of the National Health Institute, which is reflected by the fact that last year the percentage of foreigners transplanted represents only 0.27% of all procedures performed.

Disclosure

Authors declare that they do not have any conflict of interest.

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